

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Bedaquiline**

**INITIATION – multi-drug resistant tuberculosis**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- The person has multi-drug resistant tuberculosis (MDR-TB)
- and**
- Ministry of Health's Tuberculosis Clinical Network has reviewed the individual case and recommends bedaquiline as part of the treatment regimen

HOSPITAL

I confirm that the above details are correct:

Signed: ..... Date: .....